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OAH 12-0900-17119-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE COMMISSIONER OF HEALTH

In the Matter of Good Samaritan Village,
Survey Exit Date: January 4, 2006

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) meeting conducted by Administrative Law Judge Steve M. Mihalchick on May 9, 2006, at 9:30 a.m. at the Office of Administrative Hearings. The OAH record closed at the conclusion of the meeting on May 9, 2006.

Marci Martinson, Unit Supervisor, Division of Facility and Provider Compliance (DFPC), 1645 Energy Park Drive, Suite 300, St. Paul, MN 55108-2970, appeared on behalf of DFPC. Mary Cahill, Planner Principal of the Division of Compliance Monitoring, also attended the meeting.

April J. Boxeth, Voigt, Klegon & Rode, LLC, 2550 University Avenue West, Suite 190 South, St. Paul, MN 55114, appeared on behalf of Good Samaritan Village (the facility). The following persons made comments on behalf of the facility: Dr. Michael Lastine, Medical Director; Susan Kollmann, Director of Social Services; Carrie Backer, Licensed Social Worker; Pam Paulson, Registered Nurse; Sherri Hoss, Registered Nurse and Director of Nursing Services; Nancy Finzen, Registered Nursing Assistant; and Phil Samuelson, Administrator.

NOTICE

Under Minn. Stat. § 144A.10, subd.16 (d)(6), this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

FINDINGS OF FACT

1. Good Samaritan Village, located in Pipestone, is a provider of sub-acute short-term rehabilitation, assisted living, Alzheimer's/dementia care, respite care, hospice care, and traditional long-term care.

Resident #3

2. Resident #3, a 95-year-old female, was admitted to the facility on October 3, 2002, with Organic Brain Syndrome and Congestive Heart Failure.[1] She has poor orientation and short and long-term memory loss, and she lives on the facility's secured Alzheimer's unit.[2]

3. On April 21, 2005, facility staff noted in an incident report that Resident #3 had a round scratch on her mid-back and another scratch on her right upper back. In addition, facility staff noted that Resident #3 had a small bruise on her left upper arm and another on her right inner thigh.[3] The resident indicated that the two bruises were caused by rubbing the areas with a washcloth. The facility notified the resident's physician, Dr. Michael Lastine, and her family. The family noted that the resident has a history of bruising easily.[4] Dr. Lastine did not examine the resident. The facility staff did not complete the "Investigation" section of the incident report or call the Common Entry Point (CEP) to report potential maltreatment to the state.

4. Resident #3 continued to have bruising as documented by an incident report dated May 12, 2005.[5] Facility staff observed the bruise on her right upper arm and notified the resident's family and Dr. Lastine, who did not examine the resident. The investigation portion of the report was completed but the facility did not contact the CEP. The resident could not identify the cause of the bruise.

5. On August 2, 2005, an incident report indicated that Resident #3 had two bruises on her left wrist.[6] Again, the facility notified the resident's family and contacted Dr. Lastine, who did not examine the patient. The facility's investigation revealed that the resident was unaware of how the bruises occurred and suggested that the bruises could have been caused by the resident bumping into her nightstand, grab rail, sink, or walker, or by another resident of the facility. Facility staff did not notify the CEP.

6. Resident #3 continued to have bruising as documented by incident reports dated August 4 and 25, 2005; October 1, 11, 19, 22, and 28, 2005; November 9 and 24, 2005; and December 1, 2005. The bruises were on multiple areas of the resident's body including her right inner bicep, left hand between her fingers, left jawline, left upper inner thigh and right inner thigh, left posterior flank, left chest, and left posterior upper arm. The staff was largely consistent in noting the size and color of each bruise on the incident reports. On each of these occasions, the facility notified the resident's family and contacted Dr. Lastine. According to the incident reports, Dr. Lastine never physically examined the resident, but he did review her medications.

7. Most of the investigation notes emphasize that the resident bruises easily and has a history of bruising. The August 4, 2005 incident report suggested that the resident's aspirin therapy may have contributed to her bruising, but the report does not conclusively state that aspirin therapy was the

cause of the bruising.[7] Other incident reports indicate that Resident #3 may have bumped into her night stand, hand rails, or walker. At one point, the facility removed the night stand from beside the resident's bed but then later put it back so that the resident could use it for balance. The staff was reminded to use care in transferring the resident in and out of chairs. In October 2005, Dr. Lastine proposed that vascular fragility was the cause of the resident's bruising.[8] Vascular fragility is a condition in which bruises develop without known trauma on the thighs, buttocks, and upper arms.[9] Of all the bruising incidents, the facility notified the CEP on only two occasions, August 4 and October 11, 2005.[10] The facility conducted an investigation in each instance and concluded in at least five instances that the cause of the bruising was unknown or that more information was needed. In several instances, the "conclusion" portion of the incident report was not completed. Not once did the facility note that the cause of the injury was known.

Resident #5

8. Resident #5 is a 99-year-old female who was admitted to the facility on December 18, 2003.[11]

9. On October 15, 2005, facility staff completed an incident report that indicated the resident had a "fresh bruise" to her left forearm.[12] The resident stated that one of the certified nursing assistants (CNA) was being rough with her while changing the resident's clothing. The facility documented its investigation on the incident report and noted that the resident has a history of very fragile skin. The incident report characterized the occurrence as a possible "Resident-to-Staff Incident" and spoke to the CNA in question. The facility did not contact the CEP because they concluded that the incident was an accident.[13]

10. An incident report dated October 24, 2005, indicated that Resident #5 had several purple bruises on her body without describing the location, size, color, or number of bruises.[14] Progress notes for that date did make a reference to the bruises and included the resident's statement that the individual, presumably a CNA, who had helped her get dressed that morning was rough with her.[15]

11. Resident #5 has a history of being annoyed with facility staff, but the facility has no record of her making false accusations against the staff.

Resident #7

12. Resident #7 is a 94-year-old female admitted to the facility on July 3, 2002.[16]

13. On November 10, 2005, an incident report indicated that Resident #7 had a bruise on the back of her right upper arm.[17] The report stated that a possible cause of the bruising could have been staff failure to use a gait belt when transferring the resident. As additional possible causes, the report indicated that the resident often becomes combative during bath time and bruises easily. The facility took corrective action in the form of employee

education/training. The facility did not contact the CEP because the probable cause of the bruising was known.

14. An incident report dated November 17, 2005, indicated that Resident #7 had a bruise on her left wrist and three smaller bruises on her right hand.[18] The report also noted that the resident got hold of her restroom safety belt during her bath time and whipped the CNA. The report indicated that the resident often becomes combative during bath time and bruises easily. Because the CNA who assisted the resident on that day was an "excellent CNA," the facility did not suspect abuse and did not contact the CEP. The CNA communication notebook had an entry dated November 17, 2005, that reminded the CNAs to use extra care and caution when giving the resident cares, especially in the bathroom.[19]

15. Resident #7's progress notes indicate several instances of bruising between June 2005 and October 2005.[20] The record does not indicate that any of these instances were documented in an incident report or investigated.

Resident #8

16. Resident #8 is a 95-year-old female who was admitted to the facility on August 19, 1999.[21] She is blind, has dementia, and bruises easily.

17. In an incident report dated November 17, 2005, facility staff indicated that the resident had two bruises, one on her right forearm and another on the inside of her right elbow.[22] The investigation suggested that possible causes could be the resident's blindness, her tendency to lean to her right side, or the facility staff holding onto the resident too tightly during transfers. Corrective action was taken in the form of employee education/training and an amendment to the resident's care plan. A note about the resident appeared in the CNA communication book indicating that the resident needed two individuals and a gait belt to aid her ambulatory movement.[23] The results of the investigation were noted as follows: "Resident is blind and these bruises are in locations that are commonly hit. She also leans to the right side."[24] For these reasons, the facility did not suspect abuse and did not contact the CEP.

18. Resident #8's progress notes indicate two other injuries between July 2005 and September 2005.[25] The record does not indicate that either of these instances were documented in an incident report or investigated.

Resident #1

19. Resident #1 is an 89-year-old female. She was admitted to the facility on February 23, 2001, with a diagnosis including organic brain syndrome, hypothyroidism, and hypertension.[26]

20. An incident report dated September 17, 2005, indicated that the resident had a bruise on her left interior ankle.[27] The investigation suggested that the bruise could have been the result of the resident bumping her ankle on her bedside table or over-the-bed table. No corrective action was documented, and because the facility staff believed the bedside table was the probable cause of the bruise, no one contacted the CEP.

21. An incident report dated October 29, 2005,[28] documented that the resident had a bruise on the back of her left hand.[29] The facility reported the results of the investigation on the incident report form and concluded that the resident had gotten her hand stuck between her wheelchair and handrail. Facility staff did not contact the CEP.

22. Resident #1's progress notes indicate two other bruises between June 2005 and August 2005.[30] The record does not indicate that either of these instances were documented in an incident report or investigated.

23. On November 4, 2005, a staff-to-resident incident occurred, which involved Resident #1. A witness allegedly observed Nursing Assistant "E" pulling, grabbing, and squeezing the resident's wrists and arms and pinning them against her wheelchair arms. Nursing Assistant "E" was allowed to complete her shift and thereafter was terminated by the facility.

24. Shortly thereafter, the facility came under investigation by the DFPC.

Based upon the exhibits submitted and the arguments made and for the reasons set out in the Memorandum that follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

1. That the citation with regard to F-tag 225 is supported by the facts and should be affirmed as to scope and severity.

2. That the citation with regard to F-tag 514 is supported by the facts and should be affirmed as to scope and severity.

Dated: June _8th_, 2006.

/s/ Steve M. Mihalchick
STEVE M. MIHALCHICK
Administrative Law Judge

Reported: Taped, two tapes
No transcript prepared

MEMORANDUM

The DFPC partial extended survey completed January 4, 2006, was the result of a complaint investigation conducted to determine if residents of the facility had been or were being abused by Nursing Assistant "E." Two deficiencies resulted.

Tag F 225

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, *including injuries of unknown source* and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency.)[31] In addition, the facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

The interpretive guidelines in the State Operations Manual (SOM) indicate that the conditions for "injuries of unknown source" are met when: (1) the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

The interpretive guidelines in the SOM emphasize that the facility's reporting requirements include both alleged violations and results of investigations to the State survey agency.[32] The regulation indicates that alleged violations are to be reported "immediately" to the administrator and other officials in accordance with State law. The SOM indicates that "immediately" means as soon as possible, but should not exceed 24 hours after discovery of the incident.[33]

The DFPC determined that the deficient practices cited under this regulation created an Immediate Jeopardy situation in this facility. Appendix Q of the SOM provides guidance for surveyors and investigators in determining whether or not residents are in an Immediate Jeopardy situation. Appendix Q defines Immediate Jeopardy (IJ) as "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."[34]

In the interest of reducing or eliminating abuse and neglect to all beneficiaries, Appendix Q cautions surveyors that when abuse or neglect has been identified, the circumstances must be thoroughly evaluated to determine if IJ exists. The Guidelines also clarify that actual harm as well as the potential for harm, to one or to more than one individual may constitute IJ.

The identification and removal of IJ, either psychological or physical, are essential to prevent serious harm, injury, impairment, or death for individuals. Appendix Q indicates that:

- Only **ONE INDIVIDUAL** needs to be at risk. Identification of IJ for one individual will prevent risk to other individuals in similar situations.
- **Serious harm, injury, impairment, or death** does **NOT** have to occur before considering IJ. The high potential for these outcomes to occur in the very near future also constitutes IJ.
- Individuals must not be subjected to abuse by **anyone** including, but not limited to entity staff, consultants or volunteers, family members or visitors.
- Serious harm can result from both abuse and neglect.
- Psychological harm is as serious as physical harm.
- Any time a team cites abuse or neglect, it should consider IJ.

If the team identifies an IJ situation, the following points are to be considered:

- The entity either created or allowed a situation to continue which resulted in serious harm or a potential for serious harm, injury, impairment or death to individuals.
- The entity had an opportunity to implement corrective or preventive measures.[35]

Appendix Q provides potential triggers or situations in which IJ should be considered. Included in these triggers under the issue of a failure to protect from abuse are:

- Unexplained serious injuries that have not been investigated;
- Staff striking or roughly handling an individual;
- Suspicious injuries, e.g., black eyes, unexplained bruising.[36]

The investigators on site at the facility did not independently make this determination of Immediate Jeopardy. The circumstances and facts discovered through their investigation were discussed with OHFC management staff.

Resident #3: The facility argued that its treatment of Resident #3 complied with federal regulations.[37] On each of the instances that an incident report was filed, the facility relied on the resident's history of bruising easily to explain the bruising on her body. Dr. Lastine testified about aspirin therapy as well as vascular fragility and how that condition provided a sound explanation for the bruising. The facility also offered other speculative testimony about what might have caused the bruises in each instance, none of which involved maltreatment, thereby rejecting the conclusion that these were "injuries of an unknown source." Furthermore, the facility argued that it took corrective measures such as rearranging furniture in the resident's room, adding lambs wool to handles, and attaching a motion detector to the resident. A licensed social worker at the facility testified that staff interviews were done in relation to Resident #3's bruises, but admitted there is no documentation in the record to support that testimony.[38] To rule out maltreatment, the facility looked at the resident's history of bruising, the knowledge of the staff and residents, and Resident #3's pattern of behavior.

When the facility's licensed social worker was interviewed on December 22, 2005, she indicated that maltreatment by the staff really hadn't been investigated. Further, the social worker stated that she did not think that the facility had looked at the correlation between staffing and the bruising.

The Administrative Law Judge concludes that the facility has not presented sufficient evidence to demonstrate that the results of the survey were incorrect. Based upon the facility's investigation record, the surveyors reasonably determined that the facility failed to thoroughly investigate the cause of Resident #3's bruising, failed to report bruises of unknown origin to the CEP, and too quickly dismissed the possibility that maltreatment may have occurred.

Resident #5: As to the bruising incidents involving Resident #5, the facility concluded that the two incidents were accidental or unintentional because the resident is cognitively able to voice concerns to staff and her skin is highly susceptible to bruising. For these reasons, the facility did not contact the CEP.

The facility's conclusion that the two incidents were accidental or unintentional was premature. Just because the resident was cognitively sound and able to voice complaints does not mean that she necessarily will complain about her treatment. In fact, even when she did complain, the facility still did not thoroughly investigate her accusation that the CNA was rough with her when changing the resident's clothes.

The Administrative Law Judge concludes that the surveyors had a reasonable basis to conclude that the facility failed to thoroughly investigate the resident's bruises as well as allegations of maltreatment and failed to contact the CEP to report bruises of unknown origin.

Resident #7: As to the bruising incidents involving Resident #7, the facility did not contact the CEP and did not pursue a more thorough investigation because the resident was combative during baths on or about the days that the incident reports were written, the bruises in question appeared on her wrists, hands, and the back of the arm, and the CNA may have failed to use a gait belt. Furthermore, the facility failed to investigate the CNA involved in the November 17, 2005 incident because the CNA usually did such excellent work. Instead, a note was made in the CNA communications book to use extra caution when providing cares to the resident.

Again, the Administrative Law Judge concludes that the facility's decision to stop the investigation was premature. The surveyors had a reasonable basis to conclude that the facility failed to thoroughly investigate the bruises and failed to contact the CEP to report bruises of unknown origin.

Resident #8: The facility attributed its failure to contact the CEP to report Resident #8's bruises to the fact that the resident is blind and tends to bump into objects. The facility also speculated that the bruises could have occurred if a

single staff person attempted to move the resident without assistance. Accordingly, the facility made a comment in the CNA communications book to always have two people assist the resident with ambulation and did not pursue the investigation any further.

As above, the Administrative Law Judge concludes that the facility's decision to stop the investigation was premature. The surveyors had a reasonable basis to conclude that the facility failed to thoroughly investigate the bruises and failed to contact the CEP to report bruises of unknown origin.

Resident #1: As to the bruising incidents involving Resident #1, the facility did not contact the CEP and pursue a more thorough investigation because it believed that the resident's bruises were caused by her bumping into her bedside and over-the-bed tables and having her hand pinched between her wheelchair and the handrail. In addition to the bruising, Resident #1 was maltreated by Nursing Assistant E, who was allowed to finish her shift at the facility before her employment with the facility was terminated.

The Administrative Law Judge concludes that the two incidents of bruising and the maltreatment, coupled with two prior uninvestigated incidents of bruising in June and August, 2005, created a reasonable basis for the surveyors to issue a citation against the facility for failure to thoroughly investigate the bruises and contact the CEP and failure to protect the resident from Nursing Assistant E.

Overall, the facility had a systemic problem in the lack of investigations of bruises/injuries of unknown origin. A standard expectation for injuries of unknown origin is to interview staff when the bruise is discovered. If staff working at the time the bruise is discovered indicate the bruise was present when they arrived on duty, or cannot provide an explanation as to the cause of the injury, then staff on previous shifts should also be interviewed in order to attempt to determine exactly when the bruise occurred and to determine what activities, if any, might have caused the injury. Also, if there are interviewable residents on the unit, then interviewing residents in an attempt to determine if they observed any rough treatment by staff or explanations for bruising is also a common practice. After the time (date and/or shift) of origin of an injury has been determined, the next common practice is to track injuries and staffing patterns in order to determine if injuries are occurring at particular times of day, or when certain staff members work. The facility repeatedly did not make any attempt to conduct this type of investigation for the bruises of unknown injury noted on the residents. Because of this systemic lack of investigation, procedures to prevent possible abuse were not put into place and residents with dementia were placed in jeopardy of being abused. Tag F 225 should be affirmed as to scope and severity.

Tag F 514

According to federal law, the facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that

are complete; accurately documented; and systematically organized.[39] The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.[40] The intent of this regulation is to assure the facility maintains accurate, complete and organized clinical information about each resident that is readily accessible for resident care.[41]

The deficiency was issued because the facility failed to document bruises to accurately represent incidents for residents #3 and #5. The deficiency was issued at a scope and severity of D, isolated, no actual harm but the potential for more than minimal harm.[42]

Without accurate documentation of the resident's bruising patterns and tracking of the bruises, the facility assessment of the resident could not be complete, and the resident's care and treatment could be compromised putting her at risk for more than minimal harm. The facility failed to completely and thoroughly document its investigation into Resident #3's bruising and has not presented sufficient evidence to overcome the conclusion of the surveyors. Tag F 514 should be affirmed as to scope and severity.

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[1] Exhibit F-1, F-12, and F-13.
[2] Ex. F-30 and F-31.
[3] Ex. F-63a to F-64b.
[4] Ex. F-64b.
[5] Ex. F-65a to F-66b.
[6] Ex. F-68a to F-69b.
[7] Ex. F-69a to 70b.
[8] Ex. F-81 to 84.
[9] Ex. 11.
[10] Exs. F-69a to 70b and F-77 to 80.
[11] Ex. G-31.
[12] Ex. G-1 to G-4.
[13] Ex. G-41.
[14] Ex. G-5 to G-7. The third page of the incident report was not included in the hearing record.
[15] Ex. G-10a.
[16] Ex. H-17.
[17] Ex. H-1 to H-5.
[18] Ex. H-6 to H-10.
[19] Ex. H-34.
[20] Ex. H-11 to H-13.

[21] Ex. I-9.
[22] Ex. I-1 to I-6.
[23] Ex. I-6.
[24] Ex. I-4.
[25] Ex. I-25, I-28, and I-41.
[26] Ex. J-16.
[27] Ex. J-1 to J-4.
[28] All parties agree that the actual date of the incident was October 24, 2005.
[29] Ex. J-5 to J-9.
[30] Ex. J-12.
[31] 42 C.F.R. § 483.13(c)(1)(ii)-(iii).
[32] Ex. H-3.
[33] Ex. D-3.
[34] Ex. C-2.
[35] Ex. C-3.
[36] Ex. C-5.
[37] 42 C.F.R. § 483.13(c)(1)(ii)-(iii).
[38] Testimony of Carrie Backer.
[39] 42 C.F.R. § 483.75(l)(1).
[40] Ex. N-1 and N-2.
[41] Ex. N-1.
[42] Ex. B-1, B-2, and B-4. The DFPC acknowledged there was insufficient information to issue the example of Resident #5 in this deficiency. This example was removed from the Statement of Deficiencies, CMS 2567.